APPLICATION FOR LICENSURE TO PRACTICE PSYCHOLOGY IN INDIANA

State Form 27522 (R6 /11-93)
Approved by State Board of Accounts, 1988

Indiana State Psychology Board
Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
Telephone: (317) 232-2960

Application fee
Date fee paid (*Month, day, year*)
Receipt number **287 - 01 / 02**
License number
License issuance date (*Month, day, year*)

DO NOT WRITE ABOVE THIS LINE

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

Name (*Last, first, middle, maiden*)		Social Security number*		
Address (*Number, street or Rural Route*)		City	State	ZIP code
Telephone number (*Daytime*)	Birthdate (*Month, day, year*)	Birthplace		
Are you applying for licensure by: ☐ Examination ☐ Endorsement				
Do you desire a temporary license? ☐ Yes ☐ No				

* Required pursuant to I.C. 4-1-8-1

GRADUATE EDUCATION *(Doctoral)*			
Name of school	Department	Title of program	
Location	Dates attended	Degree earned	
Number of hours required for degree (*excluding dissertation hours*)?			
Which were the hours? ☐ Semester ☐ Quarter			

INTERNSHIP	
Was an Internship required for graduation? ☐ Yes ☐ No	
Name of Internship program	
Address of Internship program (*Number,street, city, state and ZIP code*)	
APA approved? ☐ Yes ☐ No	
Inclusive dates of Internship (*Months,days,years*)	Total hours worked
Name of supervising Psychologist (*Director of training*)	

POST DOCTORAL EDUCATION

Name of school	Department	Title of program

Location	Dates attended

POST DOCTORAL INTERNSHIP / FELLOWSHIP

Name of Internship/Fellowship

Address of Internship/Fellowship *(Number, street, city, state and ZIP code)*

Inclusive dates of Internship/Fellowship *(Months, days, years)*	Total hours worked

Name of supervising Psychologist *(Director of training)*

PROFESSIONAL IDENTITY BASED UPON DOCTORAL TRAINING

(Check only one or attach explanation)

- ☐ Clinical Psychology
- ☐ Counseling Psychology
- ☐ Experimental
- ☐ Developmental
- ☐ Organizational / Industrial
- ☐ School
- ☐ Social
- ☐ Other (*Specify*)

CLAIMED AREAS OF COMPETENCE

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ Yes ☐ No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation:

TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	STATE	NUMBER	DATE ISSUED	CURRENT STATUS

Have you previously taken the Examination for the Private Practice of Psychology? ☐ Yes ☐ No

If "Yes", how many times?	Date of most recent test *(Month,year)*	Where taken *(State, country)*

Have you previously filed an application for licensure as a psychologist in the State of Indiana? ☐ Yes ☐ No	If "Yes", when was the application filed?
Do you currently hold, or have you ever held, a Basic Certificate or Limited License to practice psychology in Indiana? ☐ Yes ☐ No	If "Yes", state the Certificate / License number

Are you currently in private practice? ☐ Yes ☐ No If "Yes", please complete the following:

Address (*Number and street, city, state, ZIP code*)

Number of hours (*Part or full time*)

Describe in detail the nature of your practice

Describe in detail the nature of your practice, continued:

Describe the nature of the practice of psychology in which you intend to engage:

WE MUST RECEIVE WRITTEN DOCUMENTATION FROM YOUR CURRENT OR MOST RECENT EMPLOYER VERIFYING THE FOLLOWING INFORMATION REGARDING YOUR CURRENT OR MOST RECENT EMPLOYMENT ONLY.

List all places of professional employment, including self employment, since obtaining your doctoral degree (past ten years only):

NAME AND ADDRESS OF EMPLOYER	DATES	POSITION / TITLE	RESPONSIBILITIES	HOURS / WEEK	SUPERVISOR

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date, and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a certificate or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice psychology, or any regulated health occupation in any state or country (*including Indiana*). ☐ Yes ☐ No
3. Are you now, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction ? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendere* to:
   A. A violation of any Federal,State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*.) ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Name of applicant (*Please print or type, first, middle initial, last*)	Date (*Month, day, year*)
Signature of applicant	Date (*Month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization, or institution to release to the Health Professions Bureau of Indiana, or the Indiana State Psychology Board, any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, persons and institutions from any liability with regard to such inspection or furninshing of any such information.

I further authorize the Health Professions Bureau of Indiana, or the Indiana State Psychology Board, to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Bureau, and the Board, from any and all liablility in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to same.

Signature of applicant	Date (*Month, day, year*)